

**Virginia Department of Health
Enteric Case Report Form**

Demographic Information

Name:	DOB: Age:	Race:	Sex:	SSN:
Mailing Address:	City/County:		Phone (H): (W):	
Occupation/Daycare (include location):			Parent's Name (if patient is a minor):	

Clinical Data

Disease name:		<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Epi-link to: _____	
Date of onset: ____/____/____ Time: _____	Date well: ____/____/____ Time: _____	Date of initial culture: ____/____/____	Source of report:
Symptoms (check all that apply): <input type="checkbox"/> Headache <input type="checkbox"/> Nausea <input type="checkbox"/> Abdominal cramps <input type="checkbox"/> Vomiting, How many times? _____ <input type="checkbox"/> Diarrhea, How many times? _____ <input type="checkbox"/> Bloody stool <input type="checkbox"/> Fever, How high? _____		Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No Hospital name: _____ Physician: _____ Contact #: _____	Treatment (drug name, Rx. start and end dates):

High risk situation?

- ☐ No
☐ **Yes, Specify:** ☐ Food handler ☐ Daycare employee or attendee ☐ Other, specify:
☐ Provides direct care in hospital or institutional setting _____

For all high risk cases, be sure to fill out the High Risk Cases section at the end of this form

Open-ended food history for the (____) hours/days* prior to illness onset. Use additional paper if necessary.

	Date ____/____/____	Date ____/____/____	Date ____/____/____	Date ____/____/____	Date ____/____/____	Date ____/____/____
Breakfast						
Snacks						
Lunch						
Snacks						
Dinner						
Snacks						

* Incubation periods are listed below. Collect a food history for the maximum incubation period listed:

Campylobacteriosis (2-5 days); Giardiasis (7-10 days); Salmonellosis (6-72 hours); Shigellosis (1-3 days)

Do not use this form for *E. coli* or Shiga-toxin related cases—use the *E. Coli 0157 and Shiga-toxin Related Disease Questionnaire*.

List all restaurants in which you ate, or parties, festivals, etc. that you attended during the (____) hours/days* prior to illness onset. Also list the grocery stores where you typically shop. Use additional paper if necessary.

Restaurant, party, festival or activity name	Location	Date
		___/___/___
		___/___/___
		___/___/___
Grocery Store	Address	

* Collect information for the maximum incubation period listed on page 1.

Drinking water source: ☐ Municipal ☐ Well ☐ Other, _____

Other Exposures to Water (swimming, boating, etc.): _____

Animals (e.g., pets, reptiles, livestock): _____

Recent travel history (dates, location, travel companions, etc.):

Suspected source of infection: _____

List information for all close (e.g., household, sexual) and high-risk (food, daycare, patient care) contacts:

Name	Age	Relationship to case	Symptoms (Y/N)	Date of Onset	Occupation	Culture date and results
				___/___/___		
				___/___/___		
				___/___/___		
				___/___/___		
				___/___/___		

Comments: _____

Document education: ☐ Telephone ☐ Face-to-face ☐ Letter ☐ Fact sheet ☐ Other, _____
(check all that apply) ☐ Handwashing discussed

Date received ___/___/___ Date interviewed ___/___/___ Date closed ___/___/___

Name of Investigator _____

Complete the Information Below for High Risk Cases Only

Is case restricted from workplace/daycare? ☐ Yes ☐ No Date released to return to work/daycare: ___/___/___

Has workplace/daycare been notified? ☐ Yes ☐ No Have educational materials been sent? ☐ Yes
☐ No

Name of workplace/daycare center:	Contact person:	Phone:
Address:	City/County:	If in another district, indicate: Contact person: Telephone number:

Has patient and/or contact(s) agreed to submit stool specimens? ☐ *Yes ☐ No

*If Yes, specify: ☐ Through Health Department ☐ Through Private MD

Follow-up cultures on high risk case:

Date collected: ___/___/___ Results:	Date collected: ___/___/___ Results:	Date collected: ___/___/___ Results:
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